Before the
Federal Communications Commission

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC docket No. 02-60

Comments of the Montana Telecommunications Association

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September 10, 2010

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The Montana Telecommunications Association ("MTA") is pleased to have the opportunity to file comments in response to the Commission's Notice of Proposed Rulemaking ("NPRM") regarding the Rural Health Care support mechanism.[1]

About MTA

MTA represents both member-owned cooperatives and shareholder-owned commercial rural local exchange carriers ("RLECs") serving business and residential consumers in Montana. MTA members have invested hundreds of millions of dollars in Montana's telecommunications infrastructure and continue to invest tens of millions each year in new facilities and services aimed primarily at rural Montana consumers. Collectively, Montana's RLECs have deployed over 9,000 miles of fiber optic infrastructure. They provide a state-of-the-art statewide emergency service E-911 network; and, through a consortium of RLEC members, operate a statewide middle-mile fiber backbone network, which includes nearly 200 videoconference facilities used for telemedicine, distance learning, judicial proceedings and a host of commercial purposes. MTA members provide access to broadband Internet service to over three-quarters, and in many cases as much as 100% of their customers—while serving some of

[1] Notice of Proposed Rulemaking. *In the Matter of Rural Health Care Support Mechanism*. WC Docket No. 02-60. Adopted: July 15, 2010. Released: July 15, 2010. Hereinafter, "NPRM."

the least densely populated, hardest-to-reach, high-cost areas of the nation. Montana's RLECs employ over 1,000 Montanans who substantially invest their time and resources in the communities in which they live and work.

Introduction

MTA supports the goals of the National Broadband Plan and this NPRM to expand the adoption of broadband technology to enhance the quality and delivery of health care services to America's rural citizenry. The broadband telecommunications providers comprising MTA's membership stand ready and willing to provide broadband services to any and all rural health care providers operating in MTA members' footprints.

MTA's comments build on lessons learned from the Rural Health Care Pilot Program. In this regard, MTA fundamentally disagrees with the Commission's recommendation to establish an infrastructure program that would use universal service support to build regional or statewide telecommunications networks operated and owned by health care providers. We seriously question the efficiency and efficacy of funding the construction of new infrastructure in lieu of enhancing and leveraging existing telecommunications networks as recognized by the National Broadband Plan.[2] We question whether health care providers are equipped to own and operate telecommunications enterprises. We question the perceived benefits of such an infrastructure program; and argue instead that the proposed health care infrastructure program, if implemented, would have negative consequences for rural broadband investment and economic development. And we question whether the Commission has authority

[2] Federal Communications Commission. Connecting America: The National Broadband Plan. Rel.: March 16, 2010. Chapter 1, pp. 3-5. "Due in large part to private investment and market-driven innovation, broadband in America has improved considerably in the last decade. More Americans are online at faster speeds than ever before…[T]he role of government is and should remain limited…Instead of choosing a specific path for broadband in America, this plan describes actions government should take to encourage more private innovation and investment."

under the Telecommunications Act to implement an infrastructure program as proposed.

The Proposed Health Infrastructure Program Misallocates Universal Service Funds

MTA concurs with draft comments of the American Telemedicine Association (ATA), which recommends that the Commission eliminate the infrastructure program as proposed in this NPRM.[3] ATA states in draft comments posted on its web site that "any portion of the $400 million cap in universal service healthcare funds to support broadband infrastructure construction is ill advised and that these universal service funds can be better used to support the ongoing delivery of healthcare services…[ATA's] concerns with the proposed Health Infrastructure Program…lead to the conclusion that this initiative should be cancelled and another approach taken."[4] Among other things, ATA points out that

- The proposed program would require health providers to also be in the business of telecommunications construction. This is not the expertise of healthcare providers and holds the potential of placing them in competition with commercial providers of broadband services. Many ATA members have expressed concern about this prospect.
- The program, as proposed, encourages the use of federal funds to purposely overbuild broadband networks. A provision allowing reselling of excess capacity to non-healthcare customers, at best, thwarts Congressional intent in ways that are probably not legally allowed by any other federal program.

[3] Comments of the American Telemedicine Association. *In the Matter of Notice of Proposed Rulemaking Regarding the Universal Service Support Mechanism for Rural Healthcare*. **DRAFT** : REVISED 9/6/2010. http://www.americantelemed.org/files/public/policy/ATA_FCC_RHC_Comments_9_6_2010.pdf.

[4] *id*. p. 2.

MTA has articulated these same concerns in comments before the Commission filed in January, 2010, with the Omnibus Broadband Initiative.[5] MTA noted that construction, operation and maintenance of telecommunications networks are not core competencies of health care providers. We pointed out that the 2006 Rural Health Care Order, which established the Rural health Care Pilot Program, expected rural health care providers to "present a strategy for aggregating the specific needs of health care providers…and **leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers**."[6] (Emphasis added.)

MTA contends that constructing new telecommunications infrastructure fails to satisfy the goals of leveraging existing technology, and achieving the most efficient and cost effective means of providing optimal broadband adoption by rural health care providers. On the other hand, maximizing the use of existing telecommunications infrastructure not only saves money in delivering broadband capacity to health care providers, but it enhances the scale and scope of network facilities that are used by and for all consumers.

Duplication of Telecom Facilities Discourages Broadband Investment and Wastes Universal Service Funds

Rural broadband providers have built telecommunications networks in markets that are more expensive to serve and less densely populated than more urban markets. By funding the duplication of existing network facilities, the proposed infrastructure program introduces a new, universal-service-funded provider in markets that are already high cost and hard to serve.

Many rural telecommunications providers receive federal universal service (high cost) support. Ironically, by using the Rural Health Care mechanism to fund construction of redundant telecommunications infrastructure, the proposed

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[5] Comments of the Montana Telecommunications Association. *In the Mater of Health Care Delivery Elements of the National Broadband Plan*. Docket Nos. GN 09-51 and WC 02-60. January 11, 2010.

[6] *In the Matter of Rural Health Care Support Mechanism*. WC Docket No. 02-60; FCC 06-144. Order. Adopted: September 26, 2006. "2006 Order." ¶16.

rule effectively would use one universal service support mechanism (Rural Health Care) to imperil infrastructure supported by another universal service mechanism (High Cost).

But unlike all the existing private networks in the market, even those funded in part with High Cost support, the new health care network provider would have a substantially lower capital expense profile, since the health care infrastructure program picks up 85 percent of the new network deployment costs. The health care network thus would remove, at a minimum, major health care consumers (health care provider/partners) from the public network, thereby displacing revenues needed to operate current networks. The removal of major institutional consumers from existing network operations further would threaten to displace jobs, discourage any further private investment in broadband deployment, and force rate increases for business and residential consumers that remain on the public network.

In short, the infrastructure program is narrowly focused on a short term (unsubstantiated) objective of constructing new telecommunications infrastructure. However, the wider consequences of the infrastructure program pose a direct threat to broadband deployment and economic development in Rural America, contrary to the goals of the National Broadband Plan.

The Proposed Infrastructure Program is a Solution in Search of a Problem

OBI Technical Paper No. 5 provides an "analysis of health care providers' connectivity requirements and the ability of the country's infrastructure to meet those needs."[7] Section III of the OBI Paper discusses "Gaps and Barriers Preventing Sufficient Broadband Levels." OBI asserts that "smaller providers can achieve satisfactory health IT adoption with mass-market 'small business' packages of at least 4 Mbps for single physician practices and 10 Mbps for two-

[7] Health Care Broadband In America: Early Analysis and a Path Forward. OBI Technical Paper No. 5. Federal Communications Commission. August, 2010. P. 4.

to-four physician practices…[T]he key connectivity consideration is whether or not they can access mass-market solutions of sufficient bandwidth."[8] It appears, according to OBI's assumptions, they can. Using a model as described in Technical Paper No. 1,[9] OBI estimates that less than two percent of all small health care providers, or "approximately seven percent of small physician offices" in rural areas, face a broadband connectivity gap.[10] For medium and large providers, the gap is virtually non-existent. Dedicated Internet Access (DIA), such as DS3 or Gigabit Ethernet service "is available everywhere. Broadband service providers offer customized solutions for customers who are willing to pay for them, no matter where they are located…Therefore, **the major barrier for medium and large providers is not access—it is price**." (Emphasis added.) MTA concurs. It seems that the Commission's emphasis on building infrastructure is misplaced.

The American Telemedicine Association (ATA) also questions the Commission's findings. "Such artificially high minimum speeds are considerably above current telemedicine usage in almost all of the existing telemedicine networks except in very limited cases…Telemedicine networks across the country have been operating successfully at considerably lower thresholds than those specified as minimum speeds."[11] Addressing the price issue, ATA estimated that "achieving a 10 Mbps connection (the stated minimum for a small clinic) could require…as much as $150,000 per year to meet the minimum speed

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[8] Id. p. 9.

[9] The Broadband Availability Gap. OBI Technical Paper No. 1. Federal Communications Commission. April, 2010. See also, *In the Matter of Connect America Fund; A National Broadband Plan for Our Future*; and *High-Cost Universal Service Support*. WC Docket No. 10-90; GN Docket No. 09-51 and WC Docket No. 05-337. Several comments on the *Connect America Fund* NPRM question a variety of assumptions and outputs used in the model outlined in Technical Paper No. 1 and referenced in this health care Technical Paper No. 5. See, for example, comments of CenturyLink and the Rural Coalition (NECA, NTCA, OPASTCO, Rural Alliance, and WTA).

[10] *Op cit*. "An estimated 3,600 out of approximately 307,000 small providers face a broadband connectivity gap." That is, 1.17% face a broadband connectivity gap according to the OBI model's estimates.

[11] *Op cit*. p. 9.

under this program. Even with an 85% discount, most small clinics could not afford such costs, nor would it be justified based on current utilization."[12]

The "Excess Capacity" Rule Violates the Telecommunications Act

The NPRM embraces the "excess capacity" policy that was initiated under the Rural Health Care Pilot Program. "To the extent that the deployed network has excess capacity and the eligible entities seek to share that excess capacity with ineligible entities, we propose that the ineligible entities should pay an appropriate portion of the costs of the network."[13] Translation: rural health care providers may use universal service support to build telecommunications networks with sufficient additional capacity to sell to the general public.

Further, the NPRM seeks comment on what limitations should apply to "additional capacity for use by entities that are not eligible health care providers under our rules."[14] For instance, should the Commission require that "revenues generated" by non-eligible health care providers be "retained by the network to operate, maintain and support the network[?]"[15] Or, should the rules require that "if used by non-eligible entities, the users of such excess capacity will pay (to the network) a market or arms' length negotiated rate to use such excess capacity[?]"[16] Additionally, the NPRM seeks comment on whether the proposed rules "should encourage, permit or restrict…joint projects that include additional capacity for use by the community (not for health care purposes)" including additional capacity for schools and libraries; governmental entities; and other entities such as non-profits, community or civic organizations; local businesses; anchor institutions and other residents.[17] In other words, should health care providers build telecommunications capacity for sale to the general public?

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[12] *Id*.
[13] NPRM at ¶73.
[14] *Id*. ¶76.
[15] *Id*.
[16] *Id*.
[17] *Id*. ¶78

By funding the construction of telecommunications infrastructure by health care providers, and by authorizing (indeed, encouraging) such network infrastructure to include excess capacity for sale, the proposed rule exceeds the statutory authority of the Telecommunications Act ("the Act"). As MTA pointed out in its January 11, 2010 comments, Federal universal service law establishes a Rural Health Care ("RHC") program, under which

> A **telecommunications carrier** shall, upon receiving a bona fide request, provide **telecommunications services** which are necessary for the provision of health care services…[18] (Emphasis added.)

Telecommunications services provided under the Rural Health Care program to qualified health care institutions

> may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.[19]

The Conference Report accompanying the Act affirms that "New subsection (h)(3) clarifies that telecommunications services and network capacity provided to health care providers, schools and libraries may not be resold or transferred for monetary gain."[20]

In short, the law states that *telecommunications carriers* shall provide services to health care providers, and such services may not be sold or transferred for monetary gain. The law does not authorize *health care providers* to build telecommunications facilities, to become telecommunications network providers or to sell telecommunications services. Yet, the NPRM proposes the construction, ownership and operation by health care providers of telecommunications facilities for sale, resale or other consideration.

While the Commission has argued that the construction and sale of excess capacity is not subject to the resale prohibition of §254(h)(3),[21] its

[18] 47 U.S.C. §254(h)(1)(A).
[19] 47 U.S.C. §254(h)(3).
[20] Telecommunications Act of 1996. Report 104-458. January 31, 1996. p. 133.
[21] Dana Shaffer, Chief, Wireline Competition Bureau. Letter to Scott Barash, Acting CEO of the Universal Service Administrative Company (USAC). October

explanation provides a distinction without a difference. It is likely that a court, reading the plain English of the Telecommunications Act, will have little choice but to conclude that the infrastructure program, if implemented, promotes the construction of telecommunications networks—rather than the provision of telecommunications services—by health care providers—not telecommunications service providers—for sale or other consideration by "non-eligible" entities—in violation of §254(h)(3).

Lessons Learned from the Rural Health Care Pilot Program in Montana

As discussed in MTA's January, 2010 comments, Montana provides an illustrative "case study" of how the Commission's proposed infrastructure program might unfold, if implemented as proposed. Building on lessons learned from the implementation of the Rural Health Care Pilot Program in Montana, MTA provides the following observations.

The Commission has authorized funding for a health care network construction pilot project by the Health Information Exchange of Montana (HIEM), based in Kalispell, MT.[22] The Kalispell Regional Medical Center, the lead partner in the HIEM project, has access to Gigabit Ethernet ("Gig E") service from CenturyLink. CenturyLink recently announced "mass market" availability of 25 Mbps service to over 70% of its service area, which includes Kalispell and

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24, 2008. See also, NPRM ¶ 82. "The use of such additional capacity by the community would not violate the restrictions against sale, resale or other transfer contained in section 254(h)(3) of the Act because, in such instances, health care providers would retain ownership of the additional capacity, and payments to the network for the use of such additional capacity would be retained to sustain the network." MTA fails to see the difference between "payments to the network for the use of such additional capacity" and sale of network capacity in consideration for money or other thing of value.

[22] FCC Update on Rural Healthcare Pilot Program Initiative: Six Telehealth Projects Approved for $46 million in Universal Service funds. FCC NEWS. April 16, 2009. HIEM was awarded $13.6 million for a network construction project--"a new fiber network will connect health care providers in Montana to enable distance consultation, electronic record keeping and exchange, disaster readiness, clinical research, and distance education services."

surrounding rural communities.[23] In fact, most if not all partners in the HIEM organization already have access to bandwidth at virtually any capacity they would need, through the provision by rural local exchange carriers' fiber connections to the premise.[24] Indeed, most of the HIEM partners have access to multiple network providers' broadband facilities that are capable of serving any bandwidth capacity needs the partners may demand.[25]

For example, the chief executives of InterBel Telephone Cooperative of Eureka, MT, and HIEM recently discussed an inquiry by HIEM into the availability of broadband capacity at two HIEM partners' facilities in Eureka. InterBel replied that it has fiber to the premise at both of Eureka's health clinics and can provide whatever capacity or broadband speed the clinics or HIEM desire. HIEM responded that it is not interested in using available capacity. Rather, HIEM indicated it intends to own dark fiber in order to "future proof" its health care network.[26] In addition to indicating that InterBel could provide virtually any

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[23] See attached CenturyLink flier advertising their 25 Mbps service.

[24] HIEM's initial application alleged that there was insufficient bandwidth available to HIEM partners at the time of their application—an allegation that MTA refutes. Nonetheless, the fact that there is more than enough bandwidth available to HIEM partners today demonstrates the ability of the private sector rapidly to deploy broadband facilities to address the broadband demands of all consumers. (Or, as OBI illustrates, providers can deliver DIA anywhere. P. 8, above.) If HIEM had built overlapping, or competitive, broadband facilities 5 or 10 years ago, for example, demand for capacity on existing networks (in rural areas where demand is low and expenses are high) may have been diminished, resulting in a muted response from rural providers to fill the gap. That is, by removing market demand, HIEM and similarly situated health care networks—together with the sale of excess capacity to non-eligible entities—thereby dull the market's ability to responding with commensurate supply (bandwidth capacity).

[25] Broadband providers in the HIEM footprint include, among others, 3 Rivers Communications, Blackfoot Communications, Frontier Communications, Ronan Telephone Company, Qwest, Vision Net among others. In several communities within the HIEM project footprint (e.g., Conrad, Kalispell, Ronan, St. Ignatius, Shelby), two or more of these broadband providers offer broadband service fully capable of meeting HIEM's needs.

[26] See attached letter from Randy Wilson, General Manager, InterBel Telephone Cooperative, Inc. to Kip Smith, Executive Director, HIEM. August 20, 2010. No definition of "future proofing" was provided. MTA also notes that the issue of building or leasing dark fiber has been addressed recently in comments from

bandwidth capacity desired, InterBel also pointed out that "instead of constructing a 17-mile fiber leg from Libby to the BPA fiber at Libby Dam, which would provide HIEM with a fiber ring from Kalispell to Libby to Eureka and back, HIEM has determined that constructing a 160-mile network that duplicates existing networks is a more cost effective solution."[27]

MTA does not endorse the construction, ownership or operation of any infrastructure by HIEM or other health care providers, for the reasons aforementioned. Rather, MTA cites this comment as an illustration of a lesson learned from the Pilot Program. If the facts of this example are accurate, as MTA attests, then the proposed infrastructure program, if implemented, would be expected to encourage other similar incidents of unnecessary duplication of existing telecommunications facilities, thereby constituting a waste of universal service support and a threat to broadband investment by rural broadband providers and to economic development in the communities they serve.

Conclusion

The recommended infrastructure program is a waste of universal service support funds. As OBI finds, the issue is price, not access. The proposed infrastructure program fails to take the most efficient and cost effective route to

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AT&T and USTelecom, among others, in CC Docket No. 02-6, the Schools and Libraries Universal Service Support mechanism. AT&T explained in an August 27, 2010 *ex parte* letter that §254(h) does not make dark fiber eligible for e-Rate funding. Dark fiber is not a "service" as the term is used in §254. Similarly, USTelecom in an August 30, 2010 listed several concerns with funding dark fiber under the e-Rate mechanism, including: 1) conflict with established rules; 2) impact on the universal service fund; 3) cost-effectiveness concerns; and 4) potential competitive bidding violations. The rural health care mechanism is authorized by similar language under the same §254(h), and the same concerns regarding funding dark fiber apply.

[27] Id. NOTE: in a letter to Mr. Wilson, dated September 2, 2010, Mr. Smith responded that "many of the statements which you attributed to our conversation are inaccurate and do not reflect HIEM's intent…[O]ur participation in the rural health care program to date has been in close cooperation with the FCC and USAC officials, along with the advice of Washington, DC counsel"

broadband adoption by rural health care providers: leveraging existing network facilities. Instead, the infrastructure program focuses on building new, redundant infrastructure, with excess capacity intended to be sold to non-eligible entities: i.e., the public, in apparent violation of the Telecommunications Act. By building unnecessary, duplicative infrastructure, the infrastructure program threatens to burden health care providers with operational and resource commitments that they are ill-equipped to handle. Further, the infrastructure program threatens to discourage the very broadband investment in Rural America that the National Broadband Plan is designed to promote.

MTA therefore recommends that the Commission eliminate the infrastructure program recommendation from its proposed Rural Health Care rule and instead focus the rural health care mechanism, where necessary, on promoting broadband adoption by rural health care providers through price and affordability provisions as Congress designed in the Telecommunications Act. As noted by OBI Technical Paper No. 5, mass market access and/or DIA service is available virtually everywhere. The Rural Health Care mechanism should be directed at making such services affordable to rural health care providers.

Respectfully submitted,

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September 10, 2010